FOR ARGUMENT

No. 90-97

IN THE

Supreme Court of the United States

OCTOBER TERM, 1990

AMERICAN HOSPITAL ASSOCIATION,

Petitioner,

vs.

NATIONAL LABOR RELATIONS BOARD, ET AL.,

Respondents.

On Writ Of Certiorari To The United States Court Of Appeals For The Seventh Circuit

REPLY BRIEF FOR THE PETITIONER

ARTHUR R. MILLER
1545 Massachusetts Avenue
Cambridge, Massachusetts 02138
(617) 495-4111

FREDRIC J. ENTIN
RHONDA A. RHODES
American Hospital Association
840 North Lake Shore Drive
Chicago, Illinois 60611
(312) 280-6000

JAMES D. HOLZHAUER
Counsel of Record
KENNETH S. GELLER
THOMAS C. BERG
Mayer, Brown & Platt
190 South LaSalle Street
Chicago, Illinois 60603
(312) 782-0600

Attorneys for Petitioner

Midwest Law Printing Co., Chicago 60611, (312) 321-0220

TABLE OF CONTENTS

TABLE OF AUTHORITIES

REPLY BRIEF FOR THE PETITIONER

In our opening brief, we argued that the rule issued by the National Labor Relations Board designating eight specific bargaining units as the only appropriate units for acute-care hospitals violates the requirement of Section 9(b) of the NLRA that the Board determine the appropriate bargaining unit "in each case." Congress—and the Board for over 50 years—have recognized that the question of whether a bargaining unit is appropriate "is obviously one for determination *in each individual case*" and that "[t]he complexity of modern industry, transportation, and communication, and the numerous and diverse forms which organization among employees has taken, preclude the application of rigid rules to determine the unit appropriate in each case." *1935 Leg. Hist.* at 2930; NLRB, *First Annual Report* 112 (1936).

Respondents attempt to obscure the narrow, statutory basis of our argument by characterizing it as a broadside attack on the administrative discretion and rulemaking powers of the Board and the authority of the Board to interpret the Act. See Brief for the National Labor Relations Board ("NLRB Br.") 17-20. To the contrary, our argument applies only to that subsection of the Act where Congress included language requiring individual, case-by-case determinations. Moreover, as this Court has frequently held, the notion that courts should defer to an administrative agency's interpretation of its governing statute applies only when the statute is silent or ambiguous, and not when Congress clearly intended a different interpretation.

Respondents would like this Court to believe that we propose a radical departure from the way in which the Board handles representation questions. See NLRB Br. 20. In fact, all we request is that the hospital industry receive the same individualized treatment as all other industries and that the Board determine bargaining-unit questions for hospitals exactly as it has done for all em-

ployers since 1935. As the Unions argued in 1973—and as they remind us in their brief—it is "improper to 'establish[ ] different procedures for nonprofit hospitals than for other business establishments.' " Brief for the American Nurses Association, *et al.* ("Union Br.") 27 (quoting 1973 testimony of AFL-CIO Legislative Director). It is the Board's effort to treat all hospitals as if they were identical and to dispense with the usual case-by-case method of determining bargaining units that radically departs from both tradition and the requirements of the statute.

I. The Board's Rule Is Contrary To The Requirement Of Section 9(b) That The Board Determine The Appropriate Unit "In Each Case"

A. Deference To The Board's Interpretation Of Section 9(b) Is Inappropriate When Congressional Intent Is Ascertainable

Respondents, citing *NLRB* v. *United Food & Commercial Workers Union*, 484 U.S. 112 (1987), assert that the opinion of the Board majority that Section 9(b) of the Act does not require individual, case-by-case determination of bargaining-unit appropriateness is "rational" and therefore entitled to deference from this Court. NLRB Br. 16, 26 n.22; Union Br. 9. But deference to an administrative interpretation is warranted only "where 'the statute is silent or ambiguous with respect to the specific issue.' " 484 U.S. at 123. See also *id.* at 134 (Scalia, J., concurring). Respondents ignore the fact that, "[o]n a pure question of statutory construction," the Court's

> first job is to try to determine congressional intent, using "traditional tools of statutory construction." If we can do so, then that interpretation must be given effect, and the regulations at issue must be fully consistent with it.

Id. at 123. See also *Dole* v. *Steelworkers*, 110 S. Ct. 929, 934-938 (1990); *INS* v. *Cardoza-Fonseca*, 480 U.S. 421, 446-448 (1987); *Chevron U.S.A. Inc.* v. *Natural Resources Defense Council, Inc.*, 467 U.S. 837, 842-843 & n.9 (1984); *NLRB* v. *Bell Aerospace Co.*, 416 U.S. 267, 289 (1974).

Our argument is not that the Board's rule is wholly irrational or entirely inconsistent with the general principles of the Act. If the statute were silent or ambiguous on the specific issue, the Board's rule might well be entitled to deference. But the statute is *not* silent or ambiguous on the specific issue involved in this case. As we demonstrated in our opening brief (at 13-25), the "in each case" language of Section 9(b) was clearly intended to require individual, case-by-case determinations of bargaining unit appropriateness and to preclude the adoption of the very kind of rigid rule that the Board has now adopted. In these circumstances, when "traditional tools of statutory construction" reveal a meaning inconsistent with the Board's regulation, the question of deference never arises.

B. The Language And Legislative History Of Section 9(b) Demonstrate That Individual, Case-By-Case Unit Determination Is Required

The Board's strained interpretation of Section 9(b) proves both too little and too much. In the Board's view, "the words 'in this case' refer to the proceeding in which the Board is to issue its bargaining unit determinations" (NLRB Br. 16). But if that had been the sole purpose of the language, it would not have been necessary, given the requirement of Section 9(c) that the Board "decide the appropriate unit in individual * * * cases." NLRB Br. 9.

Even on its own terms, however, the Board's interpretation of Section 9(b) is defective. Only in the most trivial sense can it be said that the Board's rule is consistent with the requirement that "the Board render its bargaining unit determinations in each individual representation proceeding" (NLRB Br. 17). To be sure, the Board's unit determinations will be announced in the context of an "individual representation proceeding" under Section 9(c). But the determinations themselves will be preordained by

the categories imposed by the Board's rule. Thus, contrary to the Board's assertion (NLRB Br. 15-16 n.8), the "dichotomy" between "individual case-by-case determinations of bargaining units" and the determinations imposed in *every* case by the Board's rigid rule is hardly "false." What is false is the Board's preposterous claim (NLRB Br. 29, 20) that its rule will not "deprive acute care hospitals of meaningful consideration of facts *material* to the Board's bargaining unit determinations" and will result in "a decision tailored to the individual case." See Pet. Br. 20.

By the same token, respondents have tried and failed to come up with some legislative history or reasonably contemporaneous interpretation of Section 9(b) to refute the mountain of evidence that the statute requires exactly what the Board over the years has held that it requires: individual, case-by-case consideration of the particular circumstances of each employer. When it added the "in each case" language to the Act, Congress explained that the decision of whether a bargaining unit is appropriate "is obviously one for determination *in each individual case.*" *1935 Leg. Hist.* at 2930, 2976, 3072 (emphasis added). Congress based its decision on the experience of the earlier New Deal labor boards, which had held that "[t]he question of the proper unit or units must be left for determination according to the circumstances of particular cases as they arise." *Houde Engineering Corp.*, 1 *Decisions of the [First] National Labor Relations Board* 35, 44 (1934).

In accordance with the language and the legislative history of the statute, the Board has consistently acknowledged that Section 9(b) precludes the adoption of rigid rules on the appropriateness of bargaining units. As recently as 1980, in a case involving an acute-care hospital, the Board held that the adoption of a conclusive presumption that a unit of registered nurses would be appropriate in every hospital would violate the Act. "Such a *per se* approach to unit determination is inconsistent with the Board's Section 9(b) responsibility to decide 'in each

case' whether the requested unit is appropriate." *Newton-Wellesley Hosp.*, 250 NLRB 409, 411 (1980).

In its first annual report, the Board recognized that Congress was wise to require individual consideration of unit appropriateness because the many differences between employers and unions "preclude the application of rigid rules to determine the unit appropriate in each case." NLRB, *First Annual Report* 112 (1936). And, as the Board now admits (NLRB Br. 24 n.19), in another early (1942) annual report it acknowledged that it had a " 'duty under the Act' to 'decide[ ] each case on the basis of all the facts and circumstances involved.' " In addition, in the first annual report issued after the Taft-Hartley Act was passed, the Board again stressed that it would "decid[e] each case on its own facts, *as it must do.*" NLRB, *Thirteenth Annual Report* 36 (1948) (emphasis added). See also the Board's *Tenth Annual Report* 26 (1945) ("The issue of appropriateness * * * must be resolved in accordance with the facts in each case"); *Eleventh Annual Report* 23-24 (1946) ("the particular facts of each case are determinative of" the issue of bargaining unit appropriateness); and *Twelfth Annual Report* 18 (1947) ("each case must be decided on its own particular facts").

The Board's repeated acknowledgment that it *must* decide each bargaining unit case "on its own facts" and "on the basis of all the facts and circumstances involved" is powerful evidence of the proper meaning of the statute. Indeed, the Board's "failure for over [50] years to exercise the power it now claims under [Section 9(b)] strongly suggests that it [has never] read the statute as granting such power." *BankAmerica Corp.* v. *United States*, 462 U.S. 122, 131 (1983). See also *FPC* v. *Panhandle Eastern Pipe Line Co.*, 337 U.S. 498, 513 (1949); *FTC* v. *Bunte Bros.*, 312 U.S. 349, 351-352 (1941).

Against all of this evidence, the Board (Br. 22) can muster only one inconclusive snippet of legislative history

that is of questionable relevance and that supports our position more than it does that of the Board. John P. Frey, President of the Metal Trades Department of the AFL, testified that he "t[ook] it for granted" (under the bill as it stood *before* the "in each case" language was added) that, "when a specific case comes to the Board, in the individual case the Board will decide which shall be the unit of representation." *1935 Leg. Hist.* at 1583. Mr. Frey then proposed his own amendment, which was somewhat different from the "in each case" language.

Mr. Frey's testimony came a full week after Secretary Perkins had offered her amendment adding the "in each case" requirement. See *1935 Leg. Hist.* at 1433, 1445, 1573 & 1583. We fail to see how this ambiguous testimony supports the Board's position. Similarly, we fail to understand how the testimony of a witness who proposed a different amendment that was never seriously considered can cast any light on the meaning of an earlier amendment that Congress in fact adopted. The Board has offered very little indeed to support its reading of Section 9(b).

C. Under The Rule, The Board Will Not Continue To Provide Meaningful, Case-By-Case Unit Determinations In The Hospital Industry

Apparently recognizing—as it has done so often in the past—that Section 9(b) *does* require individual, case-by-case determinations of bargaining unit appropriateness, the Board contends that it will continue to make such determinations under the rule and that the rule does nothing more than "narrow and define the issues." NLRB Br. 22-26. To argue that any sort of meaningful consideration will be given under the rule to the individual circumstances of any hospital is to engage in a charade.

As we demonstrated above and in our opening brief, Section 9(b) requires case-by-case unit determination in order to take into account the particular circumstances of

each employer and group of employees. As the Board and this Court have recognized, "[t]he complexity of modern industry * * * and [the] diverse forms which organization among employees has taken, preclude the application of rigid rules to determine the unit appropriate in each case" and require careful consideration of the facts of each case. NLRB, *First Annual Report* 112. See also *NLRB* v. *Hearst Publications, Inc.*, 322 U.S. 111, 134 (1944).

The Board's promise that it will continue to determine the appropriate unit based upon the facts of each case is transparently an empty one. Although the Board might still conduct a hearing in every contested case, by its own admission that hearing will be a mere formality in which the Board will mechanically apply the bargaining unit rule and will not consider the individual circumstances of the hospital involved "except in extraordinary circumstances." Final Rule, J.A. 259. Even under the "extraordinary circumstances" exception, the Board will not consider the hospital's size, staffing patterns, functional integration or increased specialization of employees, the variety of services offered by the hospital, or any of the other differences among hospitals that were "revealed at the hearings and known to the Board from more than 13 years of adjudicating cases in this field." NPR II, J.A. 189-190. In short, the Board has expressly promised that it will give *no* meaningful consideration to any of the known differences among hospitals. The Board's argument that it will continue to determine the appropriate unit "in each case" is frivolous.[1]

---

[1] The Unions argue that the rule would not apply in circumstances where it would be "accidental or unjust." Br. 21. See also NLRB Br. 30 n.28. But any fair reading of the Board's rulemaking confirms that the Board will not even consider a wide range of factors that are considered critical in every other industry. NPR II, J.A. 186-190.

D. The Board's Rule Is Not Analogous To The Bargaining Unit "Rules" It Has Announced For Other Industries

Respondents' argument (NLRB Br. 23-26; Union Br. 16-20) that the Board's rule is much the same as the "rules" it has announced for other industries is equally unavailing. The Board's acknowledgment (Br. 26) that "[t]he present regulation leaves less leeway for exceptions than many of the rules previously established" is a classic understatement. In *no* other industry has the Board established a rule—by rulemaking or adjudication—that particular units, and only those units, will be regarded as appropriate in every case. The most it has done is to establish general guidelines or rebuttable presumptions that certain units will ordinarily be considered appropriate absent contrary evidence. But as the Board concedes (Br. 24-25), those presumptions apply only "in the absence of persuasive reasons to the contrary."[2]

Accordingly, as to every other "rule" the Board and the Unions cite, the parties are given a full opportunity to demonstrate that particular circumstances warrant a different result. See, *e.g.*, *Texas Electric Service Co.*, 261 NLRB 1455 (1982), and *Tidewater Telephone Co.*, 181 NLRB 867 (1970) (under the particular facts involved, the Board declines to follow the *Baltimore Gas & Electric* "rule" that systemwide units are appropriate in the utility industry); *Orkin Exterminating Co.*, 258 NLRB 773 (1981) (the Board finds that the presumption that each separate facility in a multifacility operation should be in a separate unit has been rebutted by the facts of the particular case); *ITT Continental Baking Co.*, 231 NLRB 326 (1977), and

[2] The Unions' suggestion (Br. 10) that our argument "would require overturning countless NLRB decisions" establishing rebuttable presumptions that certain bargaining units will ordinarily be regarded as appropriate is nonsensical. *None* of the rules that the Board has announced for other industries is even remotely analogous to the rule at issue in this case.

Petrie Stores Corp., 212 NLRB 130 (1974) (the Board finds that the presumption of separate units for each store in the retail industry has been rebutted); *Journal Times Co.*, 209 NLRB 745 (1974) (Board declines to follow the rule of *Garden Island Publishing* that separate craft units are ordinarily appropriate in the newspaper industry, holding that an unusual degree of work integration warrants a more comprehensive unit); *Farmers Insurance Group*, 187 NLRB 844 (1971) (the Board holds that the presumption in favor of separate units for each district office in the insurance industry has been rebutted).[3] The approach the Board follows in these other industries is a far cry from what the Board proposes to do in the hospital industry, where it will not allow an employer even to offer evidence that the circumstances of the particular hospital warrant a departure from the general rule.[4]

[3] The Board (Br. 26 n.21) cites *Esco Corp.*, 298 NLRB No. 120 (June 20, 1990), as another case in which it has announced a "rule[ ] of decision" governing bargaining unit determinations that is analogous to the rule at issue in this case. In actuality, the Board's discussion of how it applies the presumption involved in that case (slip op. 8) demonstrates how different such presumptions are from the rigid hospital-industry rule:

> *Unit Scope*: A single plant or store unit location is presumptively appropriate unless it has been so effectively merged into a more comprehensive unit, or is so functionally integrated, that it has lost its separate identity. *Dixie Belle Mills*, 139 NLRB 629, 631 (1962). To determine if the presumption has been rebutted, the Board looks to such factors as central control over daily operations and labor relations, including the extent of local autonomy; similarity of the employee skills, functions, and working conditions; degree of employee interchange; distance between locations; and bargaining history, if any. See *Dixie Belle Mills*, supra; *Gray Drug Stores*, 197 NLRB 924, 925 (1972); *Sol's*, 272 NLRB 621 (1984); and *Bowie Hall Trucking*, 290 NLRB No. 8 (July 29, 1988).

[4] The Board's responsibility to consider the facts of each case is emphasized in one of the principal cases it misguidedly relies on for the proposition that it has adopted similar rules in other industries. In *E.H. Koester Bakery*, 136 NLRB 1006 (1962), the Board held that "the complexity of modern industry, with its many vari-

(Footnote continued on following page)

Ignoring the flexible and rebuttable nature of the "rules" the Board has announced in other industries, the Unions advance the rather bizarre argument that "the policies of the Act *demand* that unit determinations be made across an industry." Union Br. 16-19. Neither of the reasons they give for this argument can bear scrutiny. To begin with, the Unions' claim that the electoral system of the NLRA and the administrative process of the Board would collapse absent such rules cannot be taken seriously, because they have *not* collapsed even though the Board has not established rigid bargaining unit rules for any other industry. In fact, the system works quite well and the ability of employees to decide whether to self-organize for collective bargaining has been *enhanced* by the fact that organization can take place in a bargaining unit appropriate for the particular employer and group of employees.[5]

The Unions also argue that the Act *demands* uniform bargaining units across each industry in order to allow particular unions to organize entire industries, and thus

[4] *continued*
ables, precludes, for the most part, the application of fixed rules for the unit placement of truckdrivers." 136 NLRB at 1010. Application of an "automatic rule" that drivers would be included in a larger unit would amount to an improper "refusal to consider [the bargaining unit issue] on its merits." *Id.* at 1011.

[5] Respondents seem to believe that their position is somehow bolstered by the fact that the Act has long been interpreted to require only that the Board determine whether a given unit is "*an* appropriate unit, not the most appropriate unit." NLRB Br. 29. See also Union Br. 13. But that longstanding interpretation reflects the fact that designating particular units as the *most* appropriate (and therefore the *only* appropriate) units would be unduly restrictive of organizational freedom. See, *e.g.*, *Morand Bros. Beverage Co.*, 91 NLRB 409, 417-419 (1950), enforced, 190 F.2d 576 (7th Cir. 1951); *Garden State Hosiery Co.*, 74 NLRB 318, 324 (1947). In finding conclusively that the eight units listed in the rule are the *only* appropriate units in the hospital industry, the Board has eliminated the very flexibility that Congress intended it to have in determining "in each case" whether the particular unit requested is *an* appropriate unit.

to eliminate all wage competition between employers. Union Br. 18-19. That argument harkens back to the days before the Taft-Hartley Act was passed and before the national labor policy became one of neutrality on the issue of whether employees should join unions and engage in collective bargaining. See A. Cox, D. Bok, R. Gorman & M. Finkin, *Labor Law* 95 (11th ed. 1991). It is no longer national labor policy to encourage collective bargaining, and it is certainly not national labor policy to encourage unions to eliminate all wage competition in every industry by facilitating the organization of all employers in an industry by the same unions. It may be true that the ability of particular unions to organize all hospitals, to eliminate all wage differentials, and to force compliance with their other demands would be greatly increased by a rule that the same units are appropriate in every facility. But that is certainly not necessary, or even desirable, to further national labor policy.[6]

II. The Board's Rule Is Contrary To The Congressional Admonition

As we explained in our opening brief (at 26-38), the congressional admonition reflects Congress's understanding that, once the Act was applied to non-profit hospitals, the Board would continue to make bargaining unit determinations on a case-by-case basis, taking into account all of the factors considered in other industries, and would be particularly sensitive to the dangers of unit proliferation. The Board and the Unions continue to argue that in agreeing upon the congressional admonition and in passing the 1974 amendments, "Congressional and industry concern with

[6] The Board—relying primarily on *Heckler* v. *Campbell*, 461 U.S. 458 (1983)—also argues that its interpretation of the "in each case" language is consistent with the way this Court has interpreted "analogous statutes." NLRB Br. 27-28. We demonstrated in our opening brief (at 21-23) that neither *Campbell* nor the other cases cited by the Board supports the Board's position.

proliferation was directed towards the fifteen to twenty plus units that had arisen in the health care and other industries prior to the amendments and the possibility of scores of units if each hospital classification were permitted to organize separately." NLRB Br. 38, quoting J.A. 191. See also Union Br. 23-25. We find it significant that neither the Board nor the Unions can find any support for their argument in the authoritative committee reports accompanying the 1974 Act, but instead rely upon isolated statements of partisan witnesses and a few legislators.

The Board (half-heartedly) and the Unions argue that the admonition is completely irrelevant. NLRB Br. 31; Union Br. 31-36. But as the court of appeals pointed out, the 1974 amendments resulted in the application of the entire Act to the health-care industry. Thus, in "changing the domain of application of section 9(b), the 1974 amendments may have changed its meaning without changing its words." Pet. App. 11a-12a. It certainly is relevant to look at what Congress said at the time it enacted the legislation applying the Act to this industry. And the congressional admonition is the strongest kind of legislative history imaginable—a statement, obviously well thought out in advance, contained in both committee reports. Accordingly, it is not surprising that the Board, in its prior hospital bargaining unit cases, has regarded the admonition as highly significant. See, *e.g.*, *St. Francis Hosp.*, 271 NLRB 948, 951 & n.17 (1984) ("*St. Francis II*"), remanded, 814 F.2d 697 (D.C. Cir. 1987) (specifically rejecting the argument that the admonition should be disregarded in light of the fact that the earlier bill limiting the number of units was not passed); *Newton-Wellesley Hosp.*, 250 NLRB at 412; *Mercy Hosp. of Sacramento, Inc.*, 217 NLRB 765, 766-767 (1975).

Little purpose would be served by responding to the Unions' one-sided account of the 1974 legislative history, particularly since the principal sponsor of the Act—Senator Robert Taft, Jr.—has now written an article fully and fairly examining that history. Taft, "*American Hospital Association v. NLRB*: Can the NLRB Promulgate Rules Establishing *per se* Appropriate Bargaining Units for Acute Care Hospitals?" 24 *J. Health & Hosp. L.* 1 (1991).[7] We agree with Senator Taft (*id.* at 2) that "the post-enactment statements of legislators cannot and should not serve as a basis for deriving legislative intent," but we find his analysis of the pre-enactment history to be cogent and informative.

III. The Board's Rule Is Arbitrary And Capricious

In our opening brief (at 38-47), we argued that the Board's rule is arbitrary and capricious in that it ignores critical differences among acute-care hospitals, including differences in size, location, operation, and workforce organization. The court of appeals dismissed this challenge without any discussion of the evidence in the record, stating only that the Board's reasoning was "plausible" and "not unreasonable." Pet. App. 15a, 16a. Perhaps conceding the weakness of the court of appeals' discussion, the Board makes virtually no attempt to defend the rule on the grounds relied on by the court below. Instead, respondents advance a bevy of other arguments, none of which, however, supports the Board's rule.[8]

To begin with, contrary to the Board's mischaracterization (NLRB Br. 41), we do not contend that the *per se* bargaining-unit rule is arbitrary and capricious simply "because it contradicts a footnote in" *St. Francis II*. The *per se*

---

[7] We have lodged copies of Senator Taft's article with the Clerk of the Court.

[8] The Unions engage in wishful thinking when they assert (Br. 5) that AHA "does *not* challenge either the Board's finding that each of [the eight] units represents a 'natural grouping' with 'truly distinctive * * * concerns' or the Board's finding that these units are sufficiently broad and functionally distinct as not to beget whipsawing or labor unrest." Our argument throughout is that by pretending that all hospitals are alike, the Board has precluded any meaningful consideration of those important concerns in individual cases.

rule—and its underlying premise that all acute-care hospitals are "virtually identical" (*e.g.*, NPR I, J.A. 21)—is irreconcilable not just with *St. Francis II*, but with the overwhelming evidence relied on by the Board and the courts of appeals in numerous decisions before and after *St. Francis II* that the substantial differences among hospitals required that the determination of appropriate bargaining units be done on a case-by-case basis. As the Board stated in *Otis Hosp. Inc.*, 219 NLRB 164, 165 (1975):

> [N]ot all health care institutions may be exactly alike. * * * Between categories of employees similarly titled there may be significant differences, not only in wages, hours, supervision, and the like, but more importantly in functions, responsibilities, procedures, and even expertise. Practice or standards may differ from one locale to another, not only with respect to collective-bargaining patterns but also with respect to health care delivery itself.

See also, *e.g.*, *NLRB* v. *St. Francis Hosp. of Lynwood*, 601 F.2d 404, 416 (9th Cir. 1979) (registered-nurses unit appropriate in one facility may not be appropriate in another); *Newton-Wellesley Hosp.*, 250 NLRB at 415 (separate RN units "are [not] always appropriate," since "some aspects are sure to vary" among hospitals); *NLRB* v. *Frederick Memorial Hosp., Inc.*, 691 F.2d 191, 194 (4th Cir. 1982) (rejecting *per se* RN unit because a separate unit "might not be appropriate in other hospitals").[9]

Indeed, as we showed in our opening brief (at 14-19, 20), the Board's adoption of a *per se* rule here runs counter to its approach to bargaining unit determinations in every other sector of the economy. The hospital industry is the only one that the Board has treated with a blanket rule. This treatment is especially arbitrary given that the hospital industry is currently among the most diverse and dynamic in the country. It is also especially anomalous and unjustified because the congressional admonition singles out health care institutions for precisely the *opposite* treatment—requiring a sensitive analysis of whether the requested bargaining unit will lead to a proliferation of units at the particular hospital.

[9] As the Board observes (NLRB Br. 41), *St. Francis II* predicted that case-by-case adjudication itself over time would "illustrate which units are typically appropriate." 271 NLRB at 953 n.39. But determining that some units are "typically" appropriate is a far cry from declaring that those units are *always* appropriate, without *any* regard to individual circumstances however compelling.

The Board concedes (NLRB Br. 42) that in individual cases, it and the courts have previously rejected several of the separate units that it now deems *per se* appropriate. See Pet. Br. 43-45; see also *St. Francis Hosp.*, 286 NLRB 1305 (1987) ("*St. Francis III*") (maintenance unit); *St. Vincent Hosp. & Health Center*, 285 NLRB 365 (1987) (RN unit). In other words, under the close inspection of an adjudication, numerous hospitals prove to have features "inconsistent with what the Board now perceives to be industry practice as a whole"—which "in itself, tend[s] to refute any claim that the industry is uniform." Comment S-905, Humana Inc., at 2. We cited a few examples in Pet. Br. 43-45, and will add a few more here.

The rulemaking generalized that maintenance workers have different terms and conditions of employment from service workers, do not interchange positions with service workers, are separately supervised, and have only "brief, limited, and incidental" contact with other employees. NPR II, J.A. 132-137. At some hospitals, however, maintenance workers share basic terms and conditions with other employees (*St. Francis III*, 286 NLRB at 1307; *NLRB* v. *West Suburban Hosp.*, 570 F.2d 213, 216 (7th Cir. 1978)); spend a "large percentage," up to 75 or 80% of their time working with other employees (*Jewish Hosp. Ass'n*, 223 NLRB 614, 616 (1976); *NLRB* v. *West Suburban Hosp.*, 570 F.2d at 216); "transfer to service jobs and vice versa" (*Jewish Hosp. Ass'n*, 223 NLRB at 616; *St. Francis III*, 286 NLRB at 1307); and

share common supervision with other employees (*Jewish Hosp. Ass'n*, 223 NLRB at 616). Likewise, contrary to the generalizations of the rulemaking regarding the separateness of registered nurses (NPR II, J.A. 92-102), a hospital with a "multidisciplinary team approach" has been found to have "substantial interaction" between RNs and other professionals, such that an RN will have "more contact with" other professionals in her specialty area "than [with] nurses outside her specialty." *Presbyterian/St. Luke's Med. Ctr.* v. *NLRB*, 653 F.2d 450, 456 (10th Cir. 1981), cert. dismissed, 459 U.S. 1025 (1982).[10]

The Board claims that "the information obtained during the rulemaking * * * cast doubt on" its previous findings of diversity and justified treating all hospitals as if they were alike. NLRB Br. 43; see also NPR II, J.A. 115 n.22, 146-147, 159-160. But this argument is disingenuous. The Board made its decision to treat all hospitals alike *before* it received any information from the rulemaking process. See NPR I, J.A. 12-14; Transcript of NLRB Meeting of May 15, 1987, RM-2-A-1 at 18, 29 (reproduced in the Court of Appeals Supplemental Appendix at 348-349 and in our opening brief at 41-42 n.23). The Board used information received in the rulemaking—and decided what information to accept and what to disregard—*after* it had already determined to find that all hospitals were alike. The Board's "finding" was not based on information obtained during the rulemaking, and it was certainly not based on

[10] Similarly, while the rulemaking generalized that technical employees constitute a "separate and distinct" group (NPR II, J.A. 123-129), the Board has concluded that a combined unit of technical, service, and maintenance employees would be appropriate at a small hospital because the groups "work in close association" and "share common supervision" and "integrated job functions." *Vicksburg Hosp., Inc.* v. *NLRB*, 653 F.2d 1070, 1074-1075 (5th Cir. 1981) (granting enforcement).

the diametrically opposite findings it had made in prior adjudications.[11]

In the end, respondents acknowledge the many differences among hospitals—as indeed they must—but argue that this diversity is not " 'sufficiently significant to preclude uniform treatment of * * * appropriate bargaining units.' " Union Br. 38-39 (quoting NPR II, J.A. 57-58). That argument cannot be squared with the evidence adduced in the rulemaking. Extensive evidence in the record showed that many hospitals organize some or all of their workforce not along the traditional occupational lines enshrined in the rule, but instead by integrating employees in "teams" or "product lines" according to the kind of treatment such as radiology, cardiology, or oncology.[12] The

[11] The Board tries to explain away the contradictions in its previous cases by claiming that they stem from the "doctrinal approach" they employed, *i.e.*, the "disparity of interests" analysis of *St. Francis II*. NLRB Br. 43. But the contradictions in the Board's findings are attributable not to differing doctrinal frameworks, but rather to the circumstances of individual hospitals. Several of the cases that contradict the Board's rulemaking findings were analyzed under standards more liberal (in allowing separate units) than "disparity of interests." See, *e.g.*, *Jewish Hosp. Ass'n*, 223 NLRB at 616-617 (maintenance unit rejected under "community of interest" standard); *NLRB* v. *West Suburban Hosp.*, 570 F.2d at 216; *Vicksburg Hosp., Inc.* v. *NLRB*, 653 F.2d at 1074-1075.

[12] See, *e.g.*, Comment 288, Children's Medical Center (Dayton, Ohio) (hospital reorganized on "product line" approach with extensive integration across functions); Comment 248, Cedars-Sinai Medical Center (RNs participate in teams with other licensed professionals); Comment 259, Missouri Hospital Association (state study showed substantial percentage of Missouri RNs perform nontraditional functions); Comment 139, South Baltimore General Hospital (RNs share greater common interests with social workers in same department than with RNs in other departments); Comment 142, St. Anthony's Health Corporation (RNs work in 10 different departments); Comment S-1086, Beth Israel Hospital; Comment S-1279, Freeman Hospital; Comment S-1081, Wausau Hospital Center; Comment S-1375, Greater Cincinnati Hospital Council; Comment S-1082, Main Line Health, Inc.; Thompson, Chi II 14-17; Mixon, Chi II 274-275; Gallagher, 3543, 3545; Graybill, 4186 (separate RN unit could "significantly" damage "interplay" within team).

(Footnote continued on following page)

Board nevertheless resolved to apply its rigid occupation-based units to such hospitals as well, in large part because it found that they constituted a "minority" or "fewer than half" of acute-care hospitals and that where teams are used "a majority of employees do not participate on such teams." NPR II, J.A. 73. The evidence clearly showed that the team approach—even if not the majority form of organization—is sufficiently widespread to make *per se* treatment unwarranted. But the Board, in this and in other instances, arbitrarily ignored extensive evidence of diversity and cavalierly "found" that such differences among hospitals were "not typical."

Moreover, in arguing that additional bargaining units will not cause the problems Congress envisioned, the Board continues to ignore the fact that the effects of proliferation to date have not been severe because the courts have heeded the congressional admonition and have blocked attempts to establish numerous fragmented bargaining units. The Board erroneously assumes that the tolerably low level of unit proliferation that existed when the number of bargaining units was strictly controlled will continue even after those controls are suddenly removed, and that the absence of strikes and other labor unrest during the period when proliferation was prevented somehow proves that proliferation will not cause those problems. But even the court of appeals reached the commonsense conclusion

[12] *continued*

The evidence also showed that, for somewhat different reasons, cross-training and integration of functions are common at small and rural hospitals. See, *e.g.*, Comment S-1305, St. Joseph Hospital (most employees at small hospitals are "cross-trained in order to assure around-the-clock coverage"); Comment S-1673, Grayson County Hospital (because of low Medicare reimbursement and "critical" shortage of health professionals in rural areas, "many employees within a [small] hospital hold multiple job responsibilities"); Houston, 4043. [In citing to the transcripts of the various hearings on the rule, we have adopted the citation form used by the Board in the *Federal Register*. See J.A. 42-43. "Chi II", for example, is used to refer to the second Chicago hearing.]

that "[t]he more units there are," the more "work stoppages will be likel[y], because there will be more separate decisionmaking centers each of which can call a strike." Pet. App. 3a.

Finally, the Board (NLRB Br. 48 n.48) defends its steadfast refusal to respond to the disproportionate effect such increased burdens would have on some hospitals, particularly small and rural ones. But none of its justifications can withstand analysis. The Board's argument that Congress, in enacting the 1974 amendments, implicitly recognized and accepted the costs of collective bargaining (*ibid.* (quoting Final Rule, J.A. 220)) disregards the fact that Congress sought to *minimize* those costs in this particular industry by directing the Board to avoid a proliferation of units. It is undeniable that, as the Board itself recognized, the "Congressional concern in the health care amendments with the ability of health care institutions to deliver uninterrupted health services" makes it highly "relevant to consider whether multiple units increase costs to health care institutions so as to disrupt the stability of the institutions." NPR II, J.A. 84.

Yet despite this professed concern to preserve the uninterrupted provision of health care services, the Board expressly dismissed "the financial condition of rural or small hospitals" in particular as "[ir]relevant to a determination of appropriate bargaining units." Final Rule, J.A. 229-230 n.3. In so doing, the Board completely ignored the array of testimony concerning the already precarious financial state of many hospitals, the number of closings that could result from substantial increases in costs, and the devastating effect that closings could have on the availability of health care services, particularly in rural areas where one small hospital "may be the sole community provider." Comment S-1524, Falmouth Hospital.[13]

[13] See, *e.g.*, Comment S-764, Memorial Hospital ("all small, rural hospitals are severely hard pressed"); Comment S-1170, Baptist

(Footnote continued on following page)

The Board seems to believe that its regulation should be upheld simply because it is the product of a lengthy, good-faith effort to establish uniform bargaining units for the hospital industry. But neither the length of nor the motivation for that effort can overcome the Board's failure to comply with the statute and to take account of the voluminous evidence of the many relevant differences among acute-care hospitals. Congress required case-by-case determination of unit appropriateness because it recognized that the complexity of modern industry precluded the application of rigid rules in this area. That is as true for the enormously complex hospital industry as it is for any other industry.

CONCLUSION

The judgment of the court of appeals should be reversed.

Respectfully submitted.

ARTHUR R. MILLER
1545 Massachusetts Avenue
Cambridge, Massachusetts 02138

FREDRIC J. ENTIN
RHONDA A. RHODES
American Hospital Association
840 North Lake Shore Drive
Chicago, Illinois 60611

JAMES D. HOLZHAUER
Counsel of Record
KENNETH S. GELLER
THOMAS C. BERG
Mayer, Brown & Platt
190 South LaSalle Street
Chicago, Illinois 60603

Attorneys for Petitioner

February 1991

---

[13] *continued*
Health System of East Tennessee (three small hospitals closed in 1988 alone in Tennessee); Comment S-1601, Faxton Hospital (two hospitals in local area already "near the brink of closure"); Comment S-1307, United Hospital Center ("[i]n West Virginia alone, two hospitals have closed [in 1988] and other small rural hospitals are having financial difficulties"); Comment S-567, Catholic Health Corporation ("70% of the nation's hospitals under 100 beds lost money on inpatient care services" in 1987); Comment S-1257, Androscoggin Valley Hospital (rule "will accelerate the rate of closures among rural hospitals"); Comment S-1300, Bowie Memorial Hospital (detailed description of financial pressures on small and rural hospitals).